Phoenix HealthCare of Tennessee, Inc.

For the Period
January 1, 1996, Through December 31, 1997

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March 15, 1999

The Honorable Don Sundquist, Governor
and
Members of the General Assembly
State Capitol
Nashville, Tennessee 37243
and
The Honorable Fredia Wadley, M.D., Commissioner
Department of Health
344 Cordell Hull
Nashville, Tennessee 37247

Ladies and Gentlemen:

Pursuant to the agreement between the Comptroller of the Treasury and the Department of Health, the Division of State Audit performs examinations of managed care organizations participating in the Tennessee TennCare Program under Title XIX of the Social Security Act.

Submitted herewith is the report of the examination of Phoenix HealthCare of Tennessee, Inc., for the period January 1, 1996, through December 31, 1997.

Sincerely,

John G. Morgan
Comptroller of the Treasury

JGM/pn
98/111

cc: Joe Keane
Theresa Clarke-Lindsey

State of Tennessee

Audit Highlights

Comptroller of the Treasury — Division of State Audit

TennCare Report

Phoenix HealthCare of Tennessee, Inc.

For the Period January 1, 1996, through December 31, 1997

FINDINGS

Failure to Maintain Minimum Equity Requirements

Phoenix HealthCare of Tennessee, Inc., did not meet the minimum equity requirements of a health maintenance organization (page 6).

Deficiencies in Claims Processing System

Phoenix National Health Plan, Inc., did not adhere to contract reporting requirements and processing efficiency requirements for claims processing. Phoenix did not retain claims submitted by providers. Data elements required for individual encounter/claims data reporting were not recorded from claims submitted by providers. Claims were not paid or denied in the time required by the TennCare Program contract. Copies of remittance advices and provider contracts were not maintained. All possible denial reasons were not communicated to the provider (page 7).

Deficiencies In Provider Contract Language

Phoenix did not include in the provider agreements all requirements specified by the TennCare contract (page 11).

"Audit Highlights" is a summary of the report. To obtain the complete report which contains all findings, recommendations, and management comments, please contact

Comptroller of the Treasury, Division of State Audit
1500 James K. Polk Building, Nashville, TN 37243-0264
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INTRODUCTION

PURPOSE AND AUTHORITY OF THE EXAMINATION

The terms and conditions for authorizing the TennCare Program, as well as the contracts between the state of Tennessee and the managed care organizations (MCOs), require that examinations of the managed care organizations be conducted by the Tennessee Comptroller's Office. The contract between the Tennessee Department of Health and the State Comptroller's Office also contains a provision requiring the examinations.

Under their contract with the state, the MCOs have asserted that they are in compliance with stated requirements regarding their provision of services to TennCare enrollees. The purpose of our examination is to render an opinion on the MCOs' assertions that they have complied with certain financial-related requirements of their contract with the state.

BACKGROUND

The Tennessee Department of Health is the single state agency responsible for administering the TennCare Program and the TennCare Partners Program. On January 1, 1994, the TennCare Program began as an approved federal waiver replacing the then existing Medicaid Program. TennCare encompasses all services other than mental health and long-term care. On July 1, 1996, the TennCare Partners Program was initiated. TennCare Partners, which functions in the same manner as the regular TennCare Program, covers mental health services. Long-term care continues to be excluded from all TennCare waivers. The state contracts with private health maintenance organizations to provide TennCare services to beneficiaries. The health maintenance organizations are referred to as managed care organizations (MCOs).

Recipients who meet Medicaid eligibility standards are enrolled in the TennCare Program and TennCare Partners Program. In addition, certain uninsured and uninsurable individuals are eligible for enrollment. Uninsured persons may be required to pay a monthly premium. The contracting MCOs provide care for TennCare enrollees for a stated monthly capitation fee. The MCOs in turn arrange for a network of hospitals, doctors, and other health care providers to furnish health care services for persons enrolled in the plan. Essentially, the program functions much the same as a conventional health care delivery system under managed care.

Phoenix HealthCare of Tennessee, Inc., was incorporated in Tennessee on May 20, 1993, by Phoenix HealthCare Corporation, the sole shareholder, as a health maintenance organization for the purpose of providing managed health care services to residents of Tennessee, including

those participating in the State of Tennessee's TennCare Program. On September 10, 1993, Phoenix HealthCare of Tennessee, Inc., was licensed as a health maintenance organization by the Tennessee Department of Commerce and Insurance. Effective January 1, 1994, Phoenix HealthCare of Tennessee, Inc., contracted with the State of Tennessee as a health maintenance organization (HMO) to provide medical services under the newly established TennCare Program. Effective January 1, 1997, the TennCare enrollment of Healthsource Tennessee Preferred, doing business as Tennsource, was sold to Phoenix HealthCare Corporation and obtained approximately 4,100 TennCare enrollees. On December 1, 1997, Phoenix HealthCare Corporation purchased HealthNet TnCare HMO, Inc., and obtained approximately 82,000 TennCare enrollees. Enrollment in the TennCare Program for the plan was approximately 48,000 members at December 31, 1996, and approximately 173,000 members at December 31, 1997.

As a HMO, Phoenix files quarterly and annual statements with the Department of Commerce and Insurance. The department uses this information to determine if the health maintenance organization meets the minimum requirements for statutory reserves. The statements are filed on a statutory basis of accounting, which differs from generally accepted accounting principles in that "admitted" assets must be easily converted to cash to pay for outstanding claims. "Non-admitted" assets such as furniture, equipment, and prepaid expenses are not included in the determination of plan assets and are reduced from equity. The plan had a restricted deposit of $917,000 at December 31, 1996, and $3,409,787 at December 31, 1997, to satisfy requirements of the Department of Commerce and Insurance.

The annual statement for the year ended December 31, 1996, reported $9,469,642 in plan assets, $6,537,340 in liabilities, and $2,932,302 net worth. Phoenix HealthCare of Tennessee, Inc., reported total revenues of $59,636,987, expenses of $57,457,564, and provision for federal income tax of $741,004, resulting in a net income of $1,438,419 for the year ended December 31, 1996. Revenue consisted of $58,998,897 in premiums received from TennCare, $266,310 in commercial premiums, and $371,781 in investment revenue. Expenses consisted of $46,188,142 in medical expenses and $11,269,421 in administrative expenses.

The annual statement for the year ended December 31, 1997, reported $41,354,501 in plan assets, $38,975,678 in liabilities, and $2,378,823 net worth. Phoenix HealthCare of Tennessee, Inc., reported total revenues of $116,912,147, expenses of $133,758,540, and provision for federal income tax of ($3,743,562), resulting in a net loss of $13,102,831 for the year ended December 31, 1997. Revenue consisted of $115,486,215 in premiums received from TennCare, $233,216 commercial premiums, $634,425 in investment revenue, $480,568 revenue from behavioral health organizations, and $77,723 in miscellaneous revenue. Expenses consisted of $113,955,502 in medical expenses and $19,803,038 in administrative expenses.

SCOPE OF THE EXAMINATION

Our examination covers certain financial-related requirements of the contract between the state and Phoenix for the period January 1, 1996, through December 31, 1997. The requirements covered are referred to under management's assertions specified later in the Independent Accountants' report. Our examination does not cover those portions of the contract concerning quality of care, clinical, and medical requirements.

PRIOR EXAMINATION FINDINGS

The previous review of Phoenix for the year ended December 31, 1995, included the following findings:

- Deficiencies in claims-processing system—Phoenix HealthCare of Tennessee, Inc., did not provide uninsured enrollees an explanation of benefits for copayments and deductibles paid. This finding will not be repeated in the current report.

- Deficiencies in provider agreements—Phoenix HealthCare of Tennessee, Inc., did not include in provider agreements all requirements specified by the TennCare contract. This finding will be repeated in the current report (see the Findings and Recommendations section of this report).

SUBSEQUENT EVENTS

Subsequent material events affected the reporting on the annual statement for Phoenix. The TennCare statement of revenue and expenses was adjusted by the Division of State Audit as follows:

- Income tax receivable was decreased by $1,409,649 for unpaid intercompany taxes due from Phoenix.

- TennCare premium revenue and TennCare receivables were increased by $11,493 to adjust the rate increase receivable amount to the actual amount received in 1998.

- Premium taxes of $230 and management fee expenses of $1,724 were increased to reflect the additional accrual of the retroactive rate increase.

The effect of these adjustments on the net income for the TennCare operations of Phoenix would be an increase in the net loss from ($13,102,831) to ($14,502,941) as of December 31, 1997. These review adjustments will decrease equity by $1,400,110.

Independent Accountants' Report

July 22, 1998

The Honorable Don Sundquist, Governor
and
Members of the General Assembly
State Capitol
Nashville, Tennessee 37243
and
The Honorable Fredia Wadley, M.D., Commissioner
Department of Health
344 Cordell Hull
Nashville, Tennessee 37247

Ladies and Gentlemen:

We have examined management's assertion, included in its representation letter dated July 22, 1998, that Phoenix complied with the following requirement during the year ended December 31, 1996, and the year ended December 31, 1997.

- The organization has complied with its contractual duty to provide certain member services to its enrollees such as membership cards, provider directories, assignment of a primary care provider, and information on filing grievances.

As discussed in management's representation letter, management is responsible for ensuring compliance with those requirements. Our responsibility is to express an opinion on management's assertions about the organization's compliance based on our examination.

Our examination was made in accordance with standards established by the American Institute of Certified Public Accountants and, accordingly, included examining, on a test basis, evidence about Phoenix's compliance with those requirements and performing such other

procedures as we considered necessary under the circumstances. We believe that our examination provides a reasonable basis for our opinion. Our examination does not provide a legal determination on Phoenix's compliance with specified requirements.

Our examination disclosed the following material noncompliance applicable to Phoenix:

- The organization did not comply with properly classifying assets as "admitted" or "non-admitted" on the annual National Association of Insurance Commissioners (NAIC) report, which is completed on a "statutory basis of accounting" and filed with the state.

- The organization did not comply with contractual claims-processing requirements.

- The organization did not comply with contractual reporting requirements.

- The organization did not comply with contractual requirements concerning its agreements with subcontractors and providers.

- The organization did not comply with minimum equity requirements.

In our opinion, except for the material noncompliance described above, management's assertions that Phoenix complied with the aforementioned requirements for the year ended December 31, 1996, and the year ended December 31, 1997, are fairly stated, in all material respects.

This report is intended solely for the use of the Tennessee General Assembly and the Tennessee Department of Health. However, this report is a matter of public record and its distribution is not limited.

Sincerely,

Arthur A. Hayes, Jr., CPA, Director
Division of State Audit

AAH/pn

FINDINGS AND RECOMMENDATIONS

1. Failure to meet minimum equity requirements

Finding

Phoenix HealthCare of Tennessee, Inc., did not meet the minimum equity requirements of a health maintenance organization. The minimum equity at December 31, 1997, should have been $3,521,672, but the plan's adjusted equity on that date was $978,713, a deficiency of $2,542,959.

Section 2-10(e)(4) of the health maintenance organization TennCare contract states, "The Contractor shall comply with all requirements of the Tennessee Department of Commerce and Insurance applicable to risk reserves." Section 56-32-201 et seq. of *Tennessee Code Annotated* addresses the statutory requirements for health maintenance organizations.

Recommendation

Phoenix HealthCare of Tennessee, Inc., should take appropriate action to meet the minimum risk reserve requirements for TennCare operations. The Tennessee Department of Commerce and Insurance should take whatever action deemed necessary to ensure Phoenix HealthCare of Tennessee, Inc., meets the minimum equity requirements.

Management's Comment

Phoenix Healthcare disputes this finding based upon the following:

- PHT accounted for the acquisition of HealthNet TNCARE HMO ("HealthNet") as a statutory purchase rather than as a statutory merger in accordance with Statement of Statutory Accounting Principle No. 68. Based upon accounting for the acquisition as a purchase, PHT included in income only those revenues of HealthNet from the date of purchase forward. Thus, PHT's revenue base upon which the year-end statutory capital reserve was based was lower than that used by the Comptroller of the Treasury, Division of State Audit ("Comptroller").

- PHT based its December 31, 1997, reserve computation on 1996 premium revenue in accordance with T.C.A. 56-32-212, as amended effective April 8, 1997. The Comptroller based its calculation of the reserve requirement on the combined premium revenues of PHT and HealthNet for 1997.

- The income tax receivable ($1,409,649) due from Phoenix Healthcare Corporation was a valid inter-company receivable at December 31, 1997, and thus, should have been allowed as an admitted asset. The Comptroller disallowed the receivable as an admitted asset.

Rebuttal

According to statutory accounting, as determined by the Tennessee Department of Commerce and Insurance, a receivable over 90 days old is not an admitted asset. Phoenix Healthcare of Tennessee had not received the income tax receivable due from Phoenix Healthcare Corporation at the end of fieldwork. The receivable is over 90 days old and therefore, as determined by the Tennessee Department of Commerce and Insurance, is a non-admitted asset.

The Department of Commerce and Insurance maintains that in accordance with *Tennessee Code Annotated*, Section 56-32-212, the minimum equity requirements should be based on the combined revenues of Phoenix Healthcare of Tennessee and HealthNet for 1997. Based on the combined revenues, Phoenix is not in compliance with the minimum equity requirements.

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2. Deficiencies in the claims processing system

Finding

Phoenix did not fulfill contract reporting and processing efficiency requirements. Two groups of claims were selected for claims-processing testing. The first group consisted of 50 claims for dates of services January 1, 1996, through December 31, 1997. The following deficiencies were noted in this group:

- From a test of claims received in Phoenix's mailroom, it was determined that there was a four-day time lag between the actual receipt date in the mailroom and the receipt date recorded in the claims-processing system. Proper recording of the receipt date is essential in determining compliance with the timely processing requirements of the TennCare contract.

- For 17 claims, Phoenix did not enter the minimum required number of diagnoses and/or procedure codes from claims providers submitted.

- For six claims, Phoenix could not provide a copy of the claim the provider submitted; therefore information in the claims system could not be verified.

- One claim was paid incorrectly. The amount paid did not agree with the fee agreed upon in the contract with the provider.

- One claim was denied incorrectly. The claim was denied as Medicare primary payer, but there was no information in the claims system to indicate the enrollee was a Medicare recipient.

- Phoenix did not meet the claims-processing requirements specified by the TennCare contract. Claims submitted by providers for medical services were not always processed within the 60-day requirement—four of the 42 claims selected for testing. Also, Phoenix failed to pay or deny 95% of the clean claims tested within the 30-day requirement and the remaining 5% or 100% of all clean claims to be paid or denied within ten calendar days. The following time lags were noted:
  - 32 claims, 30 days (64%)
  - 8 claims, 31- to 40-day lag (16%)
  - 6 claims, 41- to 60-day lag (12%)
  - 4 claims, over 60 days (8%)

The second group of claims selected for claims-processing testing consisted of 42 claims for dates of services January 1, 1996, through December 31, 1997, but received after December 13, 1997. These were HealthNet TnCare HMO, Inc. (HealthNet) claims that Phoenix began processing after the purchase of HealthNet. The following deficiencies were noted in this group:

- For 23 claims, Phoenix could not locate the original claim submitted by the provider.
- For two claims, Phoenix did not include all possible denial codes.
- For two claims, the member should have been charged a copay but was not.
- A line-item on one claim had been submitted on an earlier claim and paid on both claims.
- One claim had two diagnosis codes on the claim, but only one diagnosis code was entered into the claims processing system.
- Phoenix did not meet the claims-processing requirements specified by the TennCare contract. Claims submitted by providers for medical services were not always processed within the 60-day requirement. Nine of the 42 claims selected for testing were not processed within 60 days. Also, Phoenix failed to pay or deny 95% of the clean claims tested within the 30-day requirement with the remaining 5% or 100% of all clean claims to be paid or denied within ten calendar days. The following time lags were noted:
  - 25 claims, with 30 days (60%)
  - 3 claims, 31- to 40-day lag (7%)
  - 5 claims, 41- to 60-day lag (12%)
  - 9 claims, over 60 days (21%)

- Phoenix could not provide copies of the remittance advices sent to providers with claim payment.

- Phoenix could not provide copies of nine provider contracts in order for auditors to determine if the claim was paid according to the contracted rates.

The inaccuracies and inefficiencies of the claims processing system uncovered by our testing show that Phoenix did not fulfill the claims-processing requirements of the TennCare contract.

Recommendation

Phoenix National Health Plan, Inc., should adhere to contract reporting requirements and processing efficiency requirements for claims processing. Phoenix should retain provider claims. All data elements required for individual encounter/claims data reporting should be recorded from claims providers submitted. Claims should be paid or denied in the time required by the TennCare Program contract. Copies of remittance advices and provider contracts should be maintained. All possible reasons for denial should be communicated to the provider.

Management's Comment

First Group of Claims Tested

Receipt Date Testing: PHT would need further information to verify this finding. Effective September 1, 1998, PHT began using the Macess scanning system to process claims. PHT is currently opening, batching, and scanning mail into the system on a daily basis. As the claims are being scanned, the system stamps the date received on the claim as well as in the computer system. PHT will be monitoring this through daily reports indicating the number of claims received and scanned compared to the number of claims entered and loaded into the system, showing the exceptions that were rejected at the point of data entry.

Diagnosis Codes: PHT concurs with the finding. PHT is in the final phase of a program enhancement that will enable additional diagnosis codes to be captured. It was PHT's former policy to enter per claim line only the diagnosis codes as indicated in Block 24E, up to two codes, instead of entering all the codes that appeared in Block 21.

Maintenance of Records: PHT concurs with the finding. PHT has implemented a plan for imaging all claims being stored off-site so that access to these claims will be immediate. PHT is also developing a new process that will include imaging claim appeals prior to being processed. This new plan is due to be implemented in the first quarter of 1999.

Incorrect Payment of Claim: PHT concurs with the finding. PHT's computer system always pays from the fee schedule that is referenced as of a particular date of service. Through additional training and increased audits, PHT is working on reducing the error rate associated with incorrect

provider setup. Errors will be reduced further with a new Quality Review Program being developed and implemented in the first quarter of 1999. PHT is in the process of auditing all provider files.

Other Insurance Denial: PHT concurs with the finding. The third-party liability information had not been loaded for the member to indicate Medicare was primary; however, the eligibility data received from TennCare's eligibility load indicated the Medicare "Dual" program code. This code identifies the member as having other coverage as well as provides a reference to the claims examiner during the adjudication process. If the claim is submitted without the other insurance carrier's EOB, the claim is appropriately denied.

Timeliness Testing: PHT concurs with the finding. PHT diverted scarce resources that would have been used to PHT claims in order to reduce the backlog of HealthNet claims acquired as a result of the purchase. PHT implemented an action plan to reduce the backlog by April 30, 1998.

Second Group of Claims Tested

Maintenance of Records: PHT concurs with the finding. PHT has implemented a plan for imaging all claims being stored off-site so that access to these claims will be immediate. PHT is also developing a new process that will include imaging claim appeals prior to being processed. This new plan is due to be implemented in the first quarter of 1999.

Adjudication Accuracy Testing: PHT concurs with the finding. The adjudication process utilized for processing the HealthNet claims was manual and therefore subject to error. All claims have now been converted to the PHT system, and any claims that may have been processed in error are being reviewed if requested by the provider.

Timeliness Testing: PHT concurs with the finding. PHT acknowledges that claims were not paid in a timely manner due to the large backlog brought over from HealthNet. PHT successfully implemented an action plan to reduce the backlog by April 30, 1998.

Remittance Advice Testing: PHT concurs with the finding. It was not possible to reprint remittance advices on the HealthNet "CSC" system. HealthNet historically maintained a carbon copy of all remittance advices and any claim processed prior to the merger. Now that the data has been converted form the old "CSC" system to PHT's system, this data can be extracted.

Provider Contract Files: PHT concurs with the finding. PHT did not receive all provider contracts from HealthNet at the time of the audit.

3. Deficiencies in provider contract language

Finding

Phoenix HealthCare of Tennessee, Inc., has not complied with the TennCare contract requirements for provider contracts. The provider agreements did not contain all requirements as specified in section 2-18 of the contract between TennCare and Phoenix HealthCare. Language describing the following requirements is excluded or deficient in contracts between Phoenix and medical providers:

- The provider may not refuse to provide medically necessary or covered preventive services to a TennCare patient.

- The provider shall render emergency services without requiring prior authorization.

- The provider shall maintain all records for a period not less than five years and records shall be made available for fiscal audit, medical audit, medical review, utilization review, and other periodic monitoring upon request of authorized representative of the MCO or TennCare.

- The provider shall safeguard information about enrollees according to applicable state and federal laws.

- The MCO shall pay the provider within 30 calendar days upon receipt of a clean claim properly submitted by the provider.

- The provider shall accept payment or appropriate denial made by the MCO (or, if applicable, payment by the MCO that is supplementary to the enrollee's third-party payer), plus the amount of any applicable deductibles, copayments and/or special fees as payment in full for covered services provided and shall not solicit or accept any surety or guarantee of payment from the enrollee in excess of the amount of applicable deductibles, copayments, and/or special fees. Enrollee shall include the patient, parent(s), guardian, spouse or any other legally responsible person of the patient.

- The provider shall indemnify and hold TennCare harmless from all claims, losses, or suits relating to activities undertaken pursuant to the Agreement between TennCare and the MCO.

- The provider shall specify that both parties recognize that in the event of termination of the agreement between the MCO and TennCare, the provider agreement shall terminate immediately and the provider shall immediately make available, to TennCare, or its designated representative, in a usable form, any or all records, whether medical or financial, related to the provider's activities undertaken pursuant to the MCO/provider agreement. The provision of such records shall be at no expense to TennCare.

- The Contractor shall submit the proposed arbitration procedure, existing alternative arbitration procedure, or any subsequent modification to the arbitration procedure to the Tennessee Department of Commerce and Insurance, TennCare Division for review and approval/denial within 30 calendar days after receipt. If a modification to the arbitration procedure is sent, it shall be sent Certified Mail–Return Receipt Requested.

- The provider shall include a conflict-of-interest clause as stated in Section 4-7 of the agreement between the MCO and TennCare.

- The provider shall be required to accept TennCare reimbursement amounts for services provided to TennCare enrollees and shall not be required to accept TennCare reimbursement amounts for services provided to persons who are covered under another health plan operated or administered by the MCO.

- The provider must adhere to the Quality of Care Monitors.

- The provider shall have at least 120 calendar days from the date of rendering a health care service to file a claim and no more 180 calendar days to file an initial claim with the MCO.

- The provider shall comply with the grievance process and shall provide grievance forms and contact information to the enrollees. The address for the submission of appeals for state review shall also be provided by the provider to the enrollees.

- Enrollees have the right to appeal adverse decisions that affect services. Notices of the right to appeal adverse decisions shall be displayed by the provider in public areas of the providers' facility.

Recommendation

Phoenix should comply with the TennCare Bureau's requirements regarding provider agreements. The provider agreements should contain all items specified in section 2-18 of the TennCare contract.

Management's Comment

PHT concurs with the finding. PHT is currently in the process of revising all provider agreements to incorporate Section 2-18 requirements.